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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G223		C 09/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	6217 16TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On August 18, 2008 at 2:46 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that on August 18, 2008, the House Manager was informed that Client #1 was discovered with a bruise on the right upper shoulder (injury of unknown origin). The bruise was measured 3 inches in length and 2 inches in width. Due to the nature of the incident, an onsite investigation was initiated on August 19, 2008 to examine the facility's incident management system and to assess the care/treatment of Client #1's injury. The investigation determined that staff failed to ensure that the injury to the client's shoulder was reported timely. Although the client had a one to one (1:1) staffing support twenty-four (24) hours a day, seven (7) days a week to assist with the management of maladaptive behaviors, the staff reportedly did not have any knowledge of the origin of the client's injury. Once the injury was discovered, on August 15, 2008, the 1:1 staff reported it 3 days later, on August 18, 2008. The investigation also determined that on the day the injury was discovered (August 15, 2008), the client had a behavioral episode and was manually/physically restrained. The behavior episode and intervention techniques used were not documented in the client's records as required by the Behavior Support Plan (BSP). Additionally, the investigation determined that the staff was not trained in the use of manual procedures/restraints. It should be noted that the facility's internal investigation suggested that the frequency of the client's behaviors and injury of this kind could have been sustained during a	W 000	Received 10/10/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance C. Reese | TITLE: Program Director | (X6) DATE: 10/8/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 behavioral episode. As a result of this investigation, the SA surveyor notified the Qualified Mental Retardation Professional (QMRP) on August 19, 2008 that the facility failed to meet the participation requirements in the Conditions of Client Behavior and Facility Practices, and Client Protection. The results of the investigation were based on interviews with 1:1 staff members, and managerial staff. Also the findings were based on the review of the client's medical and clinical records, as well as personnel and administrative records to include unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, staff interviews, and record reviews, the governing body failed to provide general operating direction over the facility as evidenced by the deficiencies throughout this report and the following. The findings include: 1. The Governing Body failed to ensure that it's policy and procedure on incident management and reporting were implemented as written. [See W149] 2. The Governing Body failed to implement policies and procedures to ensure that injuries of known were reported immediately to the the	W 104	1. The staff received adequate training from the QMRP and Residential Manager on the policy and procedure for incident management. 2. In the future, injuries of unknown source will be reported immediately to the nurse, administrators, and the state agency. However, the staff received training on reporting injuries.	9/12/08 9/12/08

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W 104	Continued From page 2 nurse, administrators, and the state agency. [See W153] 3. The Governing Body facility failed to ensure that results of all investigations were reported to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident. [See W156] 4. The governing body failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. [See W189] 5. The governing body failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs of one of one client in the investigation. [See W331]	W 104	3. In the future, the results of all investigations will be reported to the administrator and other officials within five working days of the incident. 4. Continued training will be provided to the staff on policy and procedures of job responsibilities. 5. The one-to-one staff received training on reporting incidents.	9/12/08 9/12/08 8/21/08
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based staff interviews and record reviews, the facility failed to ensure guardians were notified of serious incidents [See W148]; the facility failed to establish and implement its incident management policies that ensured each client's health and safety [See W149]; the facility failed to ensure that injuries of unknown origin are reported to the facility's administrator and government agencies as required [See W153]; the facility failed to protect four of four clients from further potential injuries pending the outcome of the investigation	W 122	Cross reference W148, W149, W153, W155, W156, W193	10/30/08

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W 122	Continued From page 3 [See W155]; facility failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident [See W156]; the facility staff failed to demonstrate competency in implementation the Behavior Support Plan [See W193]. The effects of these systemic practices resulted in the failure of the facility to protect Client #1 and ensure his health and safety.	W 122		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure guardians were notified of serious incidents for Client #1. The findings include: 1. Interview with the House Manager (HM) and review of the facility's unusual incident reports on August 19, 2008 at approximately 9:10 AM revealed that Client #1's legal guardian was notified of the injury of unknown origin to the right shoulder. A telephone interview was conducted with Client #1's guardian on August 29, 2008 at approximately 9:30 AM. The guardian revealed	W 148	1. In the future, the QMRP or Residential Manager will notify Client#1's legal guardian of any injury of unknown origin.	9/12/08

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W 148	Continued From page 4 that she was unaware of Client #1's injury to his right shoulder. The guardian further revealed that she had not received any messages left on her voice mail regarding Client #1's injury. There was no evidence that Client #1's guardian was notified immediately of the Client's injury of unknown. NOTE: Although the unusual incident report dated August 18, 2008 indicated that verbal notification of the injury was given to Client #1's attorney, interview with the HM revealed that the attorney was not notified. 2. Interview with Staff #1 on August 20, 2008 at approximately 3:00 PM revealed that Client #1 had sustained an injury to his forehead while outside at approximately 7:30 AM. Review of the incident dated August 20, 2008 on August 22, 2008 revealed that Client #1 went to retrieve a tennis ball that he was playing with and hit his head on a Staff's vehicle. The Registered Nurse assessed the injury and determined that the bump to the forehead measured 2.5 cm in with and 5 cm in length. The client was taken to the ER via the facility's van. He was subsequently treated and released with a diagnosis of a "scalp hematoma." Further review of the incident report revealed in the "verbal notification" section that Client #1's guardian was notified on August 20, 2008 at 6:00 PM. A telephone interview was conducted with Client #1's guardian on August 29, 2008 at approximately 9:32 AM. The guardian stated that she was unaware of Client #1's injury to his forehead. The guardian further stated that she had not received any messages left on her voice mail regarding Client #1's injury. There was no evidence that Client #1's guardian was notified	W 148	2. In the future, the QMRP or Residential Manager will notify Client #1's legal guardian of any injuries immediately.	9/12/08

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W 148	Continued From page 5 immediately of the Client's injury to his forehead.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish and implement its incident management policies that ensured each client's health and safety. The findings include: A. On August 18, 2008 at 2:46 PM, the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) dated August 18, 2008. The UIR revealed that the House Manager was informed that Client #1 was discovered with a bruise on the right upper shoulder (injury of unknown origin) that measured 3 inches in length and 2 inches in width. Interview with the facility's House Manager (HM) on August 19, 2008 at 9:07 AM revealed that August 18, 2008 at approximately 7:45 AM, Staff #1 informed him of Client #1's bruise shoulder. Interview with the HM revealed that during the internal investigation initiated on August 18, 2008, revealed that the bruise was first observed by the client's 1:1 staff (Staff #2) on August 15, 2008 during the evening (7:45 PM) shower. The bruise was also observed by two other staff members who failed to report the injury. Review of the Incident Management Policy (IMC)	W 149		

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W 149	Continued From page 6 dated November 11, 2006 on August 20, 2008 at approximately 3:40 PM revealed that the following procedures are to be followed once an injury of unknown origin has been observed: 1. Notify RN on call 24 hours a day by paging. Any staff not reporting within a 24 hour period will be considered negligent and can be grounds for termination. 2. Follow RN instructions and document facts on the Unusual Incident Report Form or Health Concern Form. 3. Notify the QMRP, Residential Manager, Evening/Night Manager. There was no evidence that the facility's implemented it's incident management policy. NOTE: Client's 1:1 staffing during all shifts observed the client's injury, but failed to report the injury timely. B. The facility failed to ensure investigations were completed and submitted to the state agency as required by their policy within five working days. Review of an internal investigative report was received by the State Agency (SA) via facsimile on August 26, 2008 at 3:35 PM. The investigation revealed that facility's House Manager (HM) was informed on August 18, 2008 at approximately 7:45 AM by Staff #1 that Client #1 was observed with a bruise on his upper right shoulder. The internal investigation was initiated on August 18, 2008. It could not be determined whether the investigation was completed due to lack of signature and date.	W 149	A. Cross reference W104 #1, #2, #4, and #5 B. Cross reference W104 #3	9/12/08 9/12/08

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W 149	Continued From page 7 C. The facility failed to ensure that it's nursing staff implemented the Nursing Protocol in accordance with its policy and procedures. [See W331]	W 149	C. The nursing staff will receive inservice training on the facility policy and procedure. In the future, the primary nurse will monitor nursing documentation on a monthly basis.	10/10/08
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that injuries of unknown origin are reported to the facility's administrator and government agencies as required by DC Regulation {22 DCMR Chapter 35 Section 3919.10}. The finding includes: On August 18, 2008 the House Manager was informed that Client #1 was discovered with a bruise on the right upper shoulder (injury of unknown origin) that measured 3 inches in length and 2 inches in width. Interview with the facility's House Manager (HM) on August 19, 2008 at 9:07 AM revealed that August 18, 2008 at approximately 7:45 AM, Staff #1 informed him of Client #1's bruise shoulder. Interview with the HM revealed that during the internal investigation initiated on August 18, 2008, revealed that the bruise was first observed by the	W 153	Staff will receive training on reporting incidents. Also, in the future all allegations of mistreatment, neglect, abuse, as well as injuries of unknown origin will be reported immediately to the administration and state law officials.	10/10/08

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W 153	Continued From page 8 client's 1:1 on August 15, 2008 during the evening (7:45 PM) shower. The bruise was also observed by two other staff members who failed to report the injury.	W 153		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to protect one of one client from further potential injury pending the outcome of the investigation. (Client #1) The finding includes: On August 18, 2008 the House Manager was informed that Client #1 was discovered with a bruise on the right upper shoulder (injury of unknown origin) that measured 3 inches in length and 2 inches in width. Interview with the facility's House Manager (HM) on August 19, 2008 at 9:07 AM revealed that August 18, 2008 at approximately 7:45 AM, Staff #1 informed him of Client #1's bruise shoulder. Interview with the HM revealed that during the internal investigation initiated on August 18, 2008, revealed that the bruise was first observed by the client's 1:1 staff (Staff #2) on August 15, 2008 during the evening (7:45 PM) shower. Prior to the client's shower, the client was restrained by Staff #2 in an attempt to "calm" the client as he was attempting to bite staff and peers. Staff #2 did not report the behavioral incident, the behavioral technique used, or the injury that may	W 155	In the future, staff will be put on leave immediately pending the outcome of an abuse, neglect, or mistreatment investigation.	9/12/08

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W 155	Continued From page 9 have been sustained from the behavioral episode. The facility was made aware of the client's injury on August 18, 2008 (3 days after it was first discovered).. The staff member, who was involved in the behavior episode and who first discovered the injury, continued to provide 1:1 supervision until August 20, 2008. Interview with the QMRP on August 19, 2008 at approximately 6:55 PM revealed to the State Agency (SA) that she "was leaning back/forth on placing Staff #2 on administrative leave given the findings of circumstantial evidence." The QMRP further revealed that Staff #2 failed to treat and/or report client injury to the nurse and management staff. Interview with the QMRP on August 21, 2008 at approximately 2:50 PM revealed that Staff #2 was placed on administrative leave pending the outcome of the investigation. However, a letter was received via facsimile on August 23, 2008 by the SA indicating that Staff #2 was placed on administrative leave effective August 22, 2008. There was no evidence that the facility's management staff protected Client #1 from further potential injury.	W 155		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.	W 156	Cross reference W104 #3	9/12/08

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W 156	Continued From page 10 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident. The finding includes: The facility failed to ensure investigations were completed and submitted to the administrator within five working days. Review of an internal investigative report was received by the State Agency (SA) via facsimile on August 26, 2008 at 3:35 PM. The investigation revealed that facility's House Manager (HM) was informed on August 18, 2008 at approximately 7:45 AM by Staff #1 that Client #1 was observed with a bruise on his upper right shoulder. The internal investigation was initiated on August 18, 2008. It could not be determined whether the investigation was completed due to lack of signature and date. There was also no evidence to verify that the administrator was notified of the results of the investigation.	W 156		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure first aid treatment as need and to reported injuries to the nursing personnel. The finding includes:	W 192	Cross reference W104 #1,2,4, and 5	9/12/08

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W 192	Continued From page 11 On August 19, 2008, Client #1 was observed with an upper right shoulder abrasion that measured 2" X 1/2'. The abrasion appeared to be dry with some brusing on the outer parameter. Interview with the facility's House Manager (HM) on August 19, 2008 at 9:07 AM revealed that August 18, 2008 at approximately 7:45 AM, Staff #1 informed him of Client #1's bruise shoulder. Interview with the HM revealed that during the internal investigation initiated on August 18, 2008, revealed that the bruise was first observed by the client's 1:1 staff (Staff #2) on August 15, 2008 during the evening (7:45 PM) shower. Prior to the client's shower, the client was restrained by Staff #2 in an attempted to "calm" the client as his was attempting to bite staff and peers. Staff #2 did not report the behavioral incident, the behavioral technique used or the injury that may have been sustained from the behavioral episode.	W 192		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on staff interviews and record verification, the facility staff failed to demonstrate competency in implementation the Behavior Support Plan for one of one client being investigated. (Client #1) The findings include: Interview with the House Manager on August 19, 2008 at approximately 9:16 AM revealed that on August 14, 2008 between 3:30 PM and 4:00 PM,	W 193	Staff received training from the psychologist on Client#1's BSP.	8/21/08

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W 193	Continued From page 12 and August 15, 2008 at 4:30 PM, Client #1 was aggressive and combative as he attempted to bite everyone in the home (staff and clients). The QMRP further stated that Staff #2 was observed to pull Client #1 away to keep him from biting and throwing objects. Continued interview with the QMRP revealed that as a safety precaution, all lamps were removed and all clients were asked to leave the room. Staff #2 was interview on August 19, 2008 at 4:25 PM to ascertain how he managed the client during the behavioral episode on August 14, 2008 and August 15, 2008. The staff indicated on August 14, 2008 he held Client #1 from behind under his arm pits for 15 minutes until he calmed down. Further interview with Staff #2 revealed that on August 15, 2008, Client #1 was on his hands and knees attempting to bite others as he clocked in at 4:00 PM. He again held Client #1 from behind with both hands under his arm pits to keep him and everyone else from being bitten. Staff #2 stated that he did not redirect the behavior by offering Client #1 an alternative activity to engage in. Staff #2 stated that he had received training on Client #1's Behavior Support Plan (BSP) during his orientation on August 1, 2008. Review of the Staff's orientation records failed to support training in the management of Client#1's behavioral support plan. Review of Client #1's BSP dated May 8, 2008 on August 20, 2008 revealed the client's targeted behaviors are aggression (i.e. biting others) and PICA. Further review of the BSP revealed the following proactive procedures to address biting	W 193		

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W 193	Continued From page 13 others as detailed below: a. Redirect the client to an ongoing activity when he begins to escalate, and respond, for example, in the following manner, " [client], stop biting." b. If the client is not responsive to the verbal request or the initial activity, staff should attempt to engage him in another hands on activity. c. If he does not stop after 2-3 requests, he may be moved to a safety zone, if he is not already in his room. Continued interview with the HM revealed that Staff #2 never implemented the BSP or fully understood the proactive strategies.	W 193		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview, and the record review, the facility failed to ensure that the Client #1's individual program plan included objectives to address targeted behaviors. The finding includes: Interview with the Licensed Practical Nurse (LPN) on August 19, 2006 at approximately 5:50 PM revealed that Client #1 was prescribed Buspar and Risperdal to assist with managing his maladaptive behaviors. Review of the client's	W 227	The BSP for Client #1 will be reviewed and revised to include objectives to address targeted behaviors. Staff will be trained on the revised BSP.	10/15/08

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W 227	Continued From page 14 Physician's Orders dated August 2008 revealed that the psychotropic medications was incorporated in a Behavior Support Plan (BSP) dated May 8, 2008, to address behaviors associated with aggression (i.e. biting, attempting to bite) and PICA. Review of Client #1's BSP dated May 8, 2008 on August 20, 2008 revealed the plan addressed targeted behaviors of biting, attempting to bite, and PICA. The plan however, failed to incorporate written program objectives designed to reduce the targeted behaviors.	W 227		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview, and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately for one of one clients being investigated. (Client #1) The findings include: Review of the program data failed to reflect behavioral episodes that occurred on August 14, 2008 between 3:30 PM and 4:00 PM, and August 15, 2008 at 4:30 pm. The client's behavioral support plan required that all behavioral episodes and the counselor(Staff)response be recorded. [See W193]	W 252	The QMRP and Residential Manager will train the staff on documenting consistently and accurately. The QMRP/ Residential Manager will monitor documentation weekly.	10/10/08
W 266	483.450 CLIENT BEHAVIOR & FACILITY	W 266		

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W 266	Continued From page 15 PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based interview and the review of records, the facility failed to develop and implement written policies and procedures that govern the management of inappropriate client behavior [See W274]; failed to establish policies that incorporate the use of physical restraints [See W276]; failed to ensure that prior to the implementation of more restrictive techniques, less intrusive techniques had been tried [See W278]; failed to ensure that interventions to manage inappropriate client behavior had been employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients were adequately protected [See W285]; failed to ensure that physical restraint was not used unless it was a part of the individual program plan (IPP)/Behavior Support Plan (BSP) [See W295]. The effects of these systemic practices results in the failure of the facility to provided adequate facility practices to ensure client safety.	W 266	Cross reference W274, W276, W278, W285, W295	10/15/08
W 274	483.450(b)(1) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior.	W 274		

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W 274	Continued From page 16 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement written policies and procedures that govern the management of inappropriate client behavior for one of one Client being investigated (Client #1). The finding includes: [Cross Refer to W193] On August 14th and 15th 2008 Client #1 exhibited maladaptive behaviors (combative, aggressive and attempting to bite others). Interview with the staff revealed that the client had to be restrained until he was calm. Review of the facility's policy failed to addressed procedure on safe restraining techniques.	W 274	The policy will be revised and implemented on safe restraining techniques.	10/15/08
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to approve physical restraint techinques used to manage client behaviors. The finding includes: The facility failed to provide evidence that staff interventions used to calm Client #1 down was apart of the client's Behavior Support Plan (BSP) and had been approved by the facility's Human Rights Committee. For example: Staff #2 was interview on August 19, 2008 at 4:25	W 276	The BSP for Client #1 will be reviewed and revised by the psychologist. A meeting will be scheduled with the Human Rights Committee to review the BSP Plan.	10/15/08

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W 276	Continued From page 17 PM to ascertain how he managed the client during the behavioral episode on August 14, 2008 and August 15, 2008. The staff indicated on August 14, 2008 he held Client #1 from behind under his arm pits for 15 minutes until he calmed down. Further interview with Staff #2 revealed that on August 15, 2008, Client #1 was on his hands and knees attempting to bite others as he clocked in at 4:00 PM. He again held Client #1 from behind with both hands under his arm pits to keep him and everyone else from being bitten. Review of Client #1's BSP dated May 8, 2008 on August 20, 2008 revealed under the "Circle of Support Directive", the Client #1's circle of support should not use any of the following procedures that are forbidden by facility's policy: "The use of manaual procedures/restraints for which you have not been trained." Continued interview with Staff #2 stated that he had received training on Client #1's Behavior Support Plan (BSP) during his orientation on August 1, 2008. Review of the Staff's orientation records dated August 1, 2008 failed to support training in the management of Client#1's behavioral support plan. Review of the staff in service training book failed to show evidence of training in physical restraint.	W 276		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.	W 278		

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W 278	Continued From page 18 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that prior to the implementation of more restrictive techniques, less intrusive techniques had been tried to address Client #1's behaviors. The finding includes: Interview with the House Manager on August 19, 2008 at approximately 9:16 AM revealed that on August 14, 2008 between 3:30 PM and 4:00 PM, and August 15, 2008 at 4:30 PM, Client #1 was aggressive and combative as he attempted to bite everyone in the home (staff and clients). The QMRP further stated that Staff #2 was observed to pull Client #1 away to keep him from biting and throwing objects. Continued interview with the QMRP revealed that as a safety precaution, all lamps were removed and all clients were asked to leave the room. Staff #2 was interview on August 19, 2008 at 4:25 PM to ascertain how he managed the client during the behavioral episode on August 14, 2008 and August 15, 2008. The staff indicated on August 14, 2008 he held Client #1 from behind under his arm pits for 15 minutes until he calmed down. Further interview with Staff #2 revealed that on August 15, 2008, Client #1 was on his hands and knees attempting to bite others as he clocked in at 4:00 PM. He again held Client #1 from behind with both hands under his arm pits to keep him and everyone else from being bitten. Staff #2 stated that he did not redirect behavior by offering Client #1 an alternative activity to engage in.	W 278	Cross reference W227	10/15/08

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W 278	Continued From page 19 Continued interview with the HM revealed that Staff #2 never implemented the BSP or fully understood the proactive strategies. Review of Client #1's Behavior Support Plan (BSP) dated May 8, 2008 on August 20, 2008 revealed that Client #1's had an Axis I diagnosis of Impulse Control Disorder, NOS and was prescribed Risperdal and Buspar to help manage the client's targeted behaviors are aggression (i.e. biting others) and PICA. Further review of the BSP revealed that the following proactive procedures to address biting others as detailed below: a. Redirect the client to an ongoing activity when he begins to escalate, and respond, for example, in the following manner, " [client], stop biting." b. If the client is not responsive to the verbal request or the initial activity, staff should attempt to engage him in another hands on activity. c. If he does not stop after 2-3 requests, he may be moved to a safety zone, if he is not already in his room. Review of the data collection sheets was reviewed on August 21, 2008 at approximately 4:00 PM. The data failed to evidence that the least restrictive techniques had been attempted prior to Staff #2 restricting Client #1's movement by holding him from behind with both arms under his arm pits during behavior episodes on August 14, 2008 and August 15, 2008.	W 278		
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 285		

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W 285	Continued From page 20 Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that interventions to manage inappropriate client behavior had been employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients were adequately protected. The finding includes: Interview with the House Manager on August 19, 2008 at approximately 9:16 AM revealed that on August 14, 2008 between 3:30 PM and 4:00 PM, and August 15, 2008 at 4:30 PM, Client #1 was aggressive and combative as he attempted to bite everyone in the home (staff and clients). The QMRP further stated that Staff #2 was observed to pull Client #1 away to keep him from biting and throwing objects. Continued interview with the QMRP revealed that as a safety precaution, all lamps were removed and all clients were asked to leave the room. Staff #2 was interview on August 19, 2008 at 4:25 PM to ascertain how he managed the client during the behavioral episode on August 14, 2008 and August 15, 2008. The staff indicated on August 14, 2008 he held Client #1 from behind under his arm pits for 15 minutes until he calmed down. Further interview with Staff #2 revealed that on August 15, 2008, Client #1 was on his	W 285	Cross reference W227 and W252	10/15/08

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W 285	Continued From page 21 hands and knees attempting to bite others as he clocked in at 4:00 PM. He again held Client #1 from behind with both hands under his arm pits to keep him and everyone else from being bitten. Staff #2 stated that he did not redirect behavior by offering Client #1 an alternative activity to engage in. On August 18, 2008 at 2:46 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that on August 18, 2008, the House Manager was informed that Client #1 was discovered with a bruise on the right upper shoulder (injury of unknown origin). The bruise was measured 3 inches in length and 2 inches in width. The behavior episode and intervention techniques used were not documented in the client's records as required by the Behavior Support Plan (BSP). Additionally, the investigation determined that the staff was not trained in the use of manual procedures/restraints. It should be noted that the facility's internal investigation suggested that the frequency of the client's behaviors and injury of this kind could have been sustained during a behavioral episode.	W 285		
W 295	483.450(d)(1)(i) PHYSICAL RESTRAINTS The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 295	Cross reference W276	10/15/08

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W 295	Continued From page 22 failed to ensure that physical restraint was not used unless it was a part of the individual program plan (IPP)/Behavior Support Plan (BSP) for Client #1 who was being investigated. The finding includes: The facility failed to ensure that the use of physical restraints was specified within the Client #1's Behavior Support Plan (BSP) to control the client's maladaptive behaviors. [See W193, W285]	W 295		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observations, interview, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring in accordance with client's needs for one of one client in the investigation. (Client #1) The finding includes: On August 19, 2008 at approximately 8:35 AM Client #1's right upper shoulder was observed with an abrasion that measured one 2 inches in length and a half inch in width. The abrasion appeared to be dry with some bruising around the wound. Interview with the facility's House Manager (HM) on August 19, 2008 at 9:07 AM revealed that August 18, 2008 at approximately 7:45 AM, Staff #1 informed him of Client #1's bruise shoulder. Interview with the HM revealed that during the	W 331		

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W 331	Continued From page 23 internal investigation initiated on August 18, 2008, revealed that the bruise was first observed by the client's 1:1 staff (Staff #2) on August 15, 2008 during the evening (7:45 PM) shower. On August 19, 2008 at 9:24 AM, the facility's Qualified Mental Retardation Professional (QMRP) who was also the facility's Trained Medication Employee (TME) was interviewed. The QMRP/TME consulted with the Registered Nurse (RN) who instructed her to apply Neosporin to the wound. Although she indicated that she treated the wound with neosporin, she failed to document such treatment in the clients records or on the Medication Administration Record (MAR). Interview with the facility's RN on August 19, 2008 at approximately 9:59 AM confirmed that she verbally instructed the TME to administer treatment to Client #1 right shoulder. On August 18, 2008 at 3:20 PM, the client was seen at the "offsite" nurse's office. At that time, the client was assessed by the RN and was found to have a 2 inch x I inch superficial laceration. The laceration was reassessed on August 19, 2008 and determined not be a superficial. The nurse suggested that it could have been caused by some kind of carpet burn. When asked about the wound documentation treatment, the treatment and status of the wound, the RN stated that the nursing staff should have documented in the client's record. Interview with the evening LPN on August 19, 2008 at 6:15 PM revealed that he administered medications to Client #1 on August 15, 16, 17, and 18, 2008. Further interview revealed that staff never mentioned any injuries to Client #1's	W 331	Cross reference W149	10/15/08

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W 331	Continued From page 24 right shoulder. After the morning and evening LPN was made aware of the Client #1's injury to his right shoulder effective August 19, 2008, there was no indication that they treated and documented his progress in the client's medical records. Review of Client #1's medical records book on August 20, 2008 at 2:21 PM revealed a nursing protocol. According to the nursing protocol, "the nurse note should include date and time of illness or incident, objective and/or subjective findings, plan or treatment, residents's response to treatment and any follow up needed". "The nursing staff [AM/PM] need to monitor the resident and document finding until the condition is resolved." There was no evidence that the nursing staff implemented the facility's nursing protocol to ensure that Client #1 was provided needed wound care.	W 331		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation of the medication administration, the facility's medication nurse failed to ensure all biological and drugs were locked when not being prepared. The finding includes: Observation on August 20, 2008, between the	W 382		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	6217 16TH STREET, NW WASHINGTON, DC 20012

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W 382	Continued From page 25 hours of 1:00 PM and 4:00 PM revealed that the combination lock that was used to secure the medication file was hanging on an unlock file cabinet located in the dining area. Further observation revealed that during that this time period, Client #2 was sitting at the dining table and Client #4 and unlicensed direct care staffs were walking back/forth pass the medication cabinet. Approximately 4:05 PM, the House Manager was observed to lock the combination lock. In interview with the Licensed Practical Nurse (LPN) on August 20, 2008, it was acknowledged that the medication file cabinet was required to be locked at all times when medications were not being prepared. There was no evidence that the medication file cabinet was locked when medications were not being prepared.	W 382	In the future, the nursing staff will receive disciplinary action for not securing medication cabinet. Cross reference W149	10/15/08

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I 000	INITIAL COMMENTS On August 18, 2008 at 2:46 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that on August 18, 2008, the House Mangager was informed that Client #1 was discovered with a bruise on the right upper shoulder. The bruise was measured 3 inches in length and 2 inches in width. As a result, an onsite investigation was conducted on August 19, 2008 to examine the facility's incident management system and to assess Client #1's injury. During the investigation, the SA determined that the behavior/actions of Client #1's one on one staff person resulted in deficient practices in the Condition of Governing Body & Management and Client Protections. The SA surveyor notified the Qualifed Mental Retardation Professional (QMRP) on August 19, 2008 at approximately 5:50 PM of the current findings. At 6:00 PM, the QMRP immediately implemented systems to include: conducting body checks at the end of each shift; the facility's Psychologist conducted training on Client #1's Behavior Support Plan; trained on incident reporting. The results of the investigation were based on interviews with 1:1 staff and administrative staff. Also the findings were based on the review of the client's medical record, and the facility's administrative records; including incident reports.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.	I 022		

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Constance A. Reese Program Director 10/9/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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I 022	Continued From page 1	I 022		
	This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure blinds and curtains at each window.		1. The front door window is furnished with curtains.	8/26/08
	The findings include:		2. All torn blinds will be replaced with new blinds.	8/26/08
	1. On August 20, 2008 at approximately 1:00 PM, an outside person was observed to peak into the facility through the window openings located on the front door. Interview with the Qualified Mental Retardation Professional (QMRP acknowledged that window openings on the front door should be furnished with shades, curtains, and/or blinds.			
	2. The blinds leading to the upstairs was observed to be torn.			
I 165	3507.4(c) POLICIES AND PROCEDURES	I 165		
	The manual shall incorporate policies and procedures for at least the following:		1. Cross reference W104	9/12/08
	(c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident;		2. Cross reference W149	10/10/08
	This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to establish and implement policies to ensure the health and safety for Client #1 being investigated.			
	The finding includes:			
	1. The facility failed to implement its policies and procedures for reporting incidents of injury of			

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I 165	Continued From page 2 unknown origin. [See W153] 2. The governing body failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs one of one client being investigated. [See W331]	I 165		
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure that all staff was provided job descriptions as required by this section. The finding includes: The GHMRP failed to ensure that Client #1's one on one staff (s) received a copy of their written job descriptions, which detailed each of his/her major duties and responsibilities as evidenced below: On August 21, 2008 at approximately 3:25 PM, the role and responsibilities for Client #1 was reviewed. The roles revealed Client #1's one on one staff are to implement the following rules: a. One on one staff must remain in arm reach of Client #1 at all times. b. Staff (s) identified, as the one on one for Client #1 will not have any other responsibilities to any other client in the home or for any other duties in	I 202	The QMRP/ Residential Manager will have each employee to review and sign job description annually.	8/23/08

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I 202	Continued From page 3 the home unless Client #1 is involved in the task. c. The one on one staff must always in arm reach of Client #. If for any reason the one on one staff has to leave the client (i.e. use the bathroom, take a break), the one on one staff person is responsible for ensuring that Client #1 is supervised properly by another staff person who has no other responsibilities except to monitor others at that time. d. The one on one staff is responsible for all care and training of Client #1 including but not limited to all program implementation/documentation (behavioral and habilitation), personal hygiene, medical/dental other appointments, incident reporting and involvement in community/social activities in an out of the home. e. The one on one staff is fully responsible for the implementation and documentation of Client #1's daily schedule, IPP, including seizure documentation, wheelchair protocol and other programs, procedures and techniques outlined in the ISP. f. The one on one staff is responsible for reporting and documenting any and all concerns to the Home Manager and/or QMRP as well as the medical staff and nurses in a timely manner. g. The one on one will be assigned other duties as related to Client #1. Interview with the HM/QMRP on August 21, 2008 at approximately 3:30 PM revealed the all one on one staff (s) assigned to Client #1, signed a copy of the rules for Client #1 duties and responsibilities. Review of the personnel and in service training books on August 21, 2008 at	I 202		

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I 202	Continued From page 4 approximately 4:05 PM revealed only one of six one on one staff (s) had signed the job descriptions detailing their duties. There was no evidence that all of Client #1's one on one staff (s) was afforded the opportunity to review their expected responsibilities and duties.	I 202		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on staff interviews and record verification, the GHMRP staff failed to demonstrate competency in implementation the Behavior Support Plan for one of one client being investigated. (Client #1) The findings include: Interview with the House Manager on August 19, 2008 at approximately 9:16 AM revealed that on August 14, 2008 between 3:30 PM and 4:00 PM, and August 15, 2008 at 4:30 PM, Client #1 was aggressive and combative as he attempted to bite everyone in the home (staff and clients). The QMRP further stated that Staff #2 was observed to pull Client #1 away to keep him from biting and throwing objects. Continued interview with the QMRP revealed that as a safety precaution, all lamps were removed and all clients were asked to leave the room.	I 229	Cross reference W227	10/15/08

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I 229	Continued From page 5 Staff #2 was interview on August 19, 2008 at 4:25 PM to ascertain how he managed the client during the behavioral episode on August 14, 2008 and August 15, 2008. The staff indicated on August 14, 2008 he held Client #1 from behind under his arm pits for 15 minutes until he calmed down. Further interview with Staff #2 revealed that on August 15, 2008, Client #1 was on his hands and knees attempting to bite others as he clocked in at 4:00 PM. He again held Client #1 from behind with both hands under his arm pits to keep him and everyone else from being bitten. Staff #2 stated that he had received training on Client #1's Behavior Support Plan (BSP) during his orientation on August 1, 2008. Review of Client #1's BSP dated May 8, 2008 on August 20, 2008 revealed the client's targeted behaviors are aggression (i.e. biting others) and PICA. Further review of the BSP revealed the following proactive procedures to address biting others as detailed below: a. Redirect the client to an ongoing activity when he begins to escalate, and respond, for example, in the following manner, " [client], stop biting." b. If the client is not responsive to the verbal request or the initial activity, staff should attempt to engage him in another hands on activity. c. If he does not stop after 2-3 requests, he may be moved to a safety zone, if he is not already in his room. Continued interview with the HM revealed that Staff #2 never implemented the BSP or fully understood the proactive strategies.	I 229		

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I 229	Continued From page 6 Review of the Staff's orientation records failed to support training in the management of Client#1's behavioral support plan.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that injuries of unknown origin are reported to the facility's administrator and government agencies as required by DC Regulation {22 DCMR Chapter 35 Section 3919.10}. The findings include: On August 18, 2008 at 2:46 PM, the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) dated August 18, 2008. The UIR revealed that the House Manager was informed that Client #1 was discovered with a bruise on the right upper shoulder (injury of unknown origin) that measured 3 inches in length and 2 inches in width. Interview with the facility's House Manager (HM) on August 19, 2008 at 9:07 AM revealed that	I 379	Cross reference W104, W148, and W149	10/15/08

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I 379	Continued From page 7 August 18, 2008 at approximately 7:45 AM, Staff #1 had informed him that Client #1 was observed with a bruise on his upper right shoulder that was approximately three inches in length and two inches in width. Interview with Qualified Mental Retardation Professional (QMRP) on August 19, 2008 at 9:24 AM revealed that the HM informed her of Client #1's injury on August 18, 2008 at 8:24 AM. Further interview with the HM revealed that during internal investigation initiated on August 18, 2008, Staff #2 first observed the injury Client #1's upper right shoulder on August 15, 2008 during his shower at approximately 7:45 PM. Interview with Staff #2 on August 19, 2008 at 4:25 PM revealed that on August 15, 2008 between 7:30 PM and 7:45 PM, Client #1 observed with a "burn/scrape" on Client #1's right shoulder. Further interview revealed that he did not report Client #1's injury to the nurse or management staff. Interview with Staff #4 on August 19, 2008 at 4:31 PM revealed that on August 16, 2008 at approximately 12:20 AM he saw a scrape on Client #1's right shoulder while changing his clothes. Further interview revealed that he could see Client #1's skin, but it was very clean and dry. Staff #4 stated that he did not report the injury because he thought it was old. Staff #4 further stated that he knows he should have have reported the injury to management. Interview with Staff #6 on August 19, 2008 at approximately 6:00 PM revealed that on August 17, 2008 at approximately 3:00 PM, he observed the injury to Client #1's right shoulder while changing his shirt. Further interview revealed that he thought it was an old mark. Staff #6	I 379		

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I 379	Continued From page 8 stated that he did not report the injury. Continued interview with the HM at approximately 6:15 PM revealed that Staff #2, #4, and #6 failed to implement the incident management policy, which required staff to immediately notify nursing/managerial staff of serious injuries. Review of the Incident Management Policy (IMC) dated November 11, 2006 on August 20, 2008 at approximately 3:40 PM revealed the following procedures are to be followed once an injury of unknown origin has been observed: 1. Notify RN on call 24 hours a day by paging. Any staff not reporting within a 24 hour period will be considered negligent and can be grounds for termination. 2. Follow RN instructions and document facts on the Unusual Incident Report Form or Health Concern Form. 3. Notify the QMRP, Residential Manager, Evening/Night Manager. There was no evidence that the facility's QMRP, nurse, and/or administrator, and/or Program Director was immediately notified within 24 hours of the incident as indicated in the IMP. NOTE: It should be noted that Client #1 has 24 hour 1:1 services. It should be further noted that Staff #2, #4, and #6 are 1:1 support staffs for Client #1. 2. Also See Federal Deficiency Report Citation - Citation W148 and W149	I 379		

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I 401	Continued From page 9	I 401		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		
	Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.		Cross reference W149	10/10/08
	This Statute is not met as evidenced by: Based on observations, interview, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring in accordance with client's needs for one of one client in the investigation. (Client #1)			
	The finding includes:			
	On August 19, 2008 at approximately 8:35 AM Client #1's right upper shoulder was observed with an abrasion that measured one 2 inches in length and a half inch in width. The abrasion appeared to be dry with some bruising around the wound.			
	Interview with the facility's House Manager on August 19, 2008 at 9:07 AM revealed that on August 18, 2008 at approximately 7:45 AM, Staff #1 had informed him that Client #1 was observed with a bruise on his upper right shoulder that was approximately three inches in length and two inches in width. Further interview with the HM revealed that during internal investigation initiated on August 18, 2008, Staff #2 first observed the injury Client #1's right shoulder on August 15, 2008 while giving him a bath at approximately 7:45 PM.			
	Interview with the facility's Qualified Mental			

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I 401	Continued From page 10 Retardation Professional who is a Trained Medication Employee on August 19, 2008 at 9:24 AM revealed that she applied standard First Aid treatment [Neosporin] to Client #1's right shoulder after consulting with the facility's Registered Nurse. Further interview revealed she did not document Client #1's treatment to the right shoulder on the Medication Administration Record. Interview with the facility's RN on August 19, 2008 at approximately 9:59 AM confirmed that she verbally instructed the TME to administer treatment to Client #1 right shoulder on August 18, 2008. The RN revealed that Client #1 was assessed and was found to had a 2 inch superficial laceration in length and approximately 1 inch in width to his right shoulder during his visit to the nurse's office on August 18, 2008 at 3:20 PM. Further interview revealed that the injury was an abrasion and not a superficial laceration, which appeared to have been caused by some kind of carpet burn. When asked by the treatment to Client #1's injury, the RN stated that the [AM/PM] nursing staff should have documented progress on the nurse's progress notes of the treatment given and the response to the treatments in Client #1's medical record. Interview with the evening LPN on August 19, 2008 at 6:15 PM revealed that he administered medications to Client #1 on August 15, 16, 17, and 18, 2008. Further interview revealed that staff never mentioned any injuries to Client #1's right shoulder. After the morning and evening LPN was made aware of the Client #1's injury to his right shoulder effective August 19, 2008, there was no indication that they treated and	I 401		

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I 401	Continued From page 11 documented his progress in the client's medical records. Review of Client #1's medical records book on August 20, 2008 at 2:21 PM revealed a nursing protocol. According to the nursing protocol, "the nurse note should include date and time of illness or incident, objective and/or subjective findings, plan or treatment, residents's response to treatment and any follow up needed". "The nursing staff [AM/PM] need to monitor the resident and document finding until the condition is resolved." There was no evidence that the nursing staff implemented the facility's nursing protocol.	I 401		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each resident's rights were observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws. The findings include: (See Federal Deficiency Report Citations W149, W153, W155, and W156)	I 500	Cross reference W149, W153, W155, and W156	10/15/08